Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	**Management of Pennine Care's Policy Set**
Version:	**8**
Reference Number:	**CO001**

Scope:

This policy applies to all policies, standards, procedures and guidelines developed by Pennine Care NHS Foundation Trust and all employees involved in the development, management and review of these documents.

Purpose:

The purpose of this document is to describe the provision of a robust and supported approach to policy and guideline development and management and provide clarity and consistency to the process of production, approval, adherence monitoring and review.

Pennine Care NHS FT will develop policies to fulfil all statutory and organisational requirements and these will be concise, consistent, approved and shared using appropriate channels.

Requirement for Policy

Organisational requirement, Good Governance

Keywords:

Policy on policies, policy review, developing a policy, policy panel, guidelines, PMT

Supersedes:

CO1, Policy, protocol and guidance policy, version 7

Description of Amendment(s):

This document has been given an overall redesign to describe the new governance process developed to manage document development, approval, implementation, monitoring and review, taking into consideration elements such as freedom of information exemption assessment, the general data protection regulations, equality impact analysis and reflecting the Trust's policy set with CQC regulations and NICE guidance. The document also introduces the new policy management team, the policy and guideline panel and support and resources available to subject matter experts, authors and owners.

Owner:

Linda Chadburn, Clinical Effectiveness & Quality Improvement Lead

Individual(s) & group(s) involved in the Development:	
This document has been developed in collaboration with the following interested parties: • Freedom of Information Lead • Information Governance Department • Head of Safeguarding • Equality & Diversity Manager • Managing Directors and Governance Managers	
Individual(s) & group(s) involved in the Consultation:	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: • Trust Management Board	
Equality Impact Analysis:	
Date approved:	4th September 2018
Reference:	CO001-EIA001
Freedom of Information Exemption Assessment:	
Date approved:	25th July 2018
Reference:	POL2018-29
Information Governance Assessment:	
Date approved:	25th July 2018
Reference:	POL2018-29
Policy Panel:	
Date Presented to Panel:	6th September 2018
Presented by:	Linda Chadburn
Date Approved by Panel:	6th September 2018
Policy Management Team tasks:	
Date Trust Management Board informed:	18th September 2018
Date uploaded to Trust's intranet:	13th September 2018
Date uploaded to Trust's internet site:	13th September 2018
Review:	
Next review date:	September 2021
Responsibility of:	Clinical Effectiveness & Quality Improvement Lead and the Policy Management Team

Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
Freedom of Information Exemption Assessment Guide	
Equality Impact Analysis Guidance	
Policy Associated Documents:	
CO001_HTG_A	How to complete the document control
CO001_HTG_B	How to identify key words
CO001_HTG_C	How to search and locate the best evidence
CO001_HTG_D	How to involve the right people
CO001_HTG_E	How to identify feasible and appropriate training requirements
CO001_HTG_F	How to monitor adherence to a policy / guideline
CO001_HTG_G	How to reference
CO001_HTG_H	How to prepare for presentation to the Panel
CO001_HTG_I	How to develop a flowchart
CO001_HTG_J	How to format a policy / guideline
CO001_HTG_K	How to attach appendices
CO001_HTG_L	How to manage version control
CO001_HTG_M	How to complete the EqIA documentation
CO001_HTG_N	How to decide where to publish and raise awareness
Other External Documentation/resources to which this policy relates:	
None	
CQC Regulations **This guideline supports the following CQC regulations:**	
	Good Governance

Contents Page

1. INTRODUCTION

1.1 Our Vision, Purpose, Values and Goals

The Trust's vision is to deliver the best care to patients, people and families in our local communities by working effectively with partners to help people to live well.

Our purpose is to help communities to live healthy lives, acting with integrity and upholding our values.

Our values are to be compassionate, accountable, responsive, effective and safe.

Our goals are to put local people and communities first, provide high quality whole person care, to deliver safe and sustainable services, be a valued partner and that the organisation is a great place to work.

Pennine Care NHS FT's policy set is aimed to describe the accountability, responsibility and provide guidance to support the Trust's goals, values, purpose and overarching vision.

1.2 Policy Is Not the Only Option

It is important to use the most appropriate document for the type of information being shared and Fig 1 illustrates the hierarchy of formal documents and provides a simple definition of each.

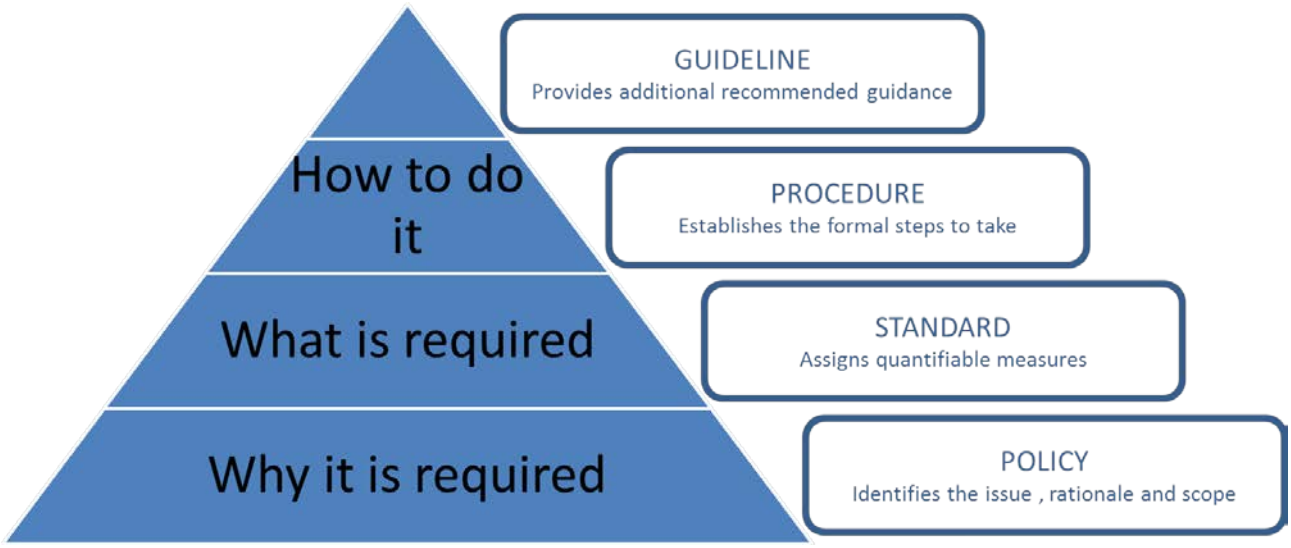


Fig 1: The Hierarchy of organisational documents

A **guideline** provides an overview of how to perform a task and provides recommended advice (and even additional advice recommended by local subject matter experts to meet organisational need) on how to act in a given situation. A guideline does not state mandatory controls and therefore monitoring practice against a guideline should be undertaken with caution; after all a guideline is not compulsory.

A **procedure** is written to support a policy directive and is designed to describe who, what, where, when and why by establishing corporate accountability to implement a policy.

A **standard** is an approved document that provides rules, guidelines for processes which compliance is not mandatory.

A **policy** is an organisation-level document that prescribes acceptable methods or behaviours; i.e. describes the way things are done within the organisation.

1.3 Introducing the Trust's Policy Set

Clinical (CL)

This set of documents provide a formal, brief and high-level statement or plan that embraces the organisation's general beliefs, goals, objectives and acceptable procedures within delivery of clinical care. Policies always state required actions, and may include pointers to standards and guidelines. A clinical policy requires compliance; i.e. is mandatory, and failure to comply with a clinical policy could result in disciplinary action.

Clinical Guidelines (GL)

This set of documents recommends how healthcare professionals should care for people with specific conditions. They cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management. A guideline can be changed frequently based on the environment and should be reviewed more frequently than standards and policies. A guideline is not mandatory, rather a suggestion of a best practice.

Corporate (CO)

This set of documents provides formal statements defining the principles by which Pennine Care NHS Foundation Trust operates and the parameters of required individual conduct.

Emergency Planning (EP)

This set of documents describes the courses of action developed to mitigate the damage of potential events that could endanger the Trust's ability to function effectively and efficiently.

Finance (F)

This set of documents sets out the financial rules and regulations that every officer of the Trust, and its constituent organisations, must adhere to in relation to the utilisation of public monies. This includes the procurement of goods and services, expenditure on pay / staffing and any other type of payment made with public funds. It details levels of authority relating to expenditure and also delegation of powers in relation to making decisions required in running the Trust. These documents are designed to ensure that financial transactions are carried out in accordance with the law and requirements of the Independent Regulator, in order to achieve probity, accuracy, economy, efficiency and effectiveness. They also outline what everyone's responsibility is in relation to preventing fraud, bribery and corruption, how to report it and the intended outcomes of anti-fraud work.

Health Informatics (HI)

This set of documents describes the appropriate application of technologies to improve health care and health within Pennine Care NHS Foundation Trust.

Human Resource (HR)

The Workforce department is responsible for providing a service to the Trust leading on all human resource matters ensuring best practice in resourcing, workforce management and employee relations.

HR policies and procedures assist Pennine Care NHS Foundation Trust in establishing and maintaining consistent practices in the workplace and are continually developed and reviewed in partnership with our recognised Trade Unions.

There are a significant number of HR policies, procedures and guidance available in regards to recruitment and retention, employee reward and recognition, Health and Wellbeing, employee relations, employee engagement, terms and conditions of service and equality and diversity. Further advice and guidance on interpretation can be sought from your HR team.

Health & Safety (HS)

This set of documents defines regulations and procedures intended to prevent accident or injury in the workplace.

Information Governance (IG)

This set of documents assist Pennine Care NHS Foundation staff, and anyone performing a duty on behalf of Pennine Care, in establishing and maintaining consistent practices in the workplace which are compliant with relevant information law and national standards. The objective is to both support the Trust's compliance with legislation and the rights of data subjects.

There are a number of IG policies, procedures and guidance available, including Data Protection, Freedom of Information, Information Security and Risk, Information Sharing, Consent and an Information Governance Staff Handbook.

Further advice and guidance on specific concerns or queries can be sought from the Trust IG team.

Infection Prevention & Control (IPC)

This set of documents describes practical, evidence-based approaches to the clinical application of microbiology aimed to prevent patients and staff from being harmed and ensure quality health care.

Records Management (RM)

This set of documents assist Pennine Care NHS Foundation staff, and anyone performing a duty on behalf of Pennine Care, in establishing and maintaining consistent practices in the workplace in relation to Records Management. The objective is to both support the Trust's compliance with relevant legislation and the rights of data subjects.

There are a number of Records Management policies and guidelines available in regards to business and corporate and clinical record keeping protocols; records retention schedules; records management moving protocol; missing records protocol and procedure for uploading and scanning documents onto electronic patient records.

Further advice and guidance on specific concerns or queries can be sought from the Trust Records Management team.

2. PURPOSE

The purpose of this document is to describe the provision of a robust and supported approach to policy and guideline development and management and provide clarity and consistency to the process of production, approval, adherence monitoring and review.

Pennine Care NHS FT will develop policies to fulfil all statutory and organisational requirements and these will be concise, consistent, approved and shared using appropriate channels.

3. RESPONSIBILITIES, ACCOUNTABILITIES & DUTIES

3.1 Executive Team

The Executive Team is responsible for receiving notification of all policies and guidelines reviewed and developed prior to internal and external publication.

3.2 Executive Directors

All Executive Directors are responsible for identifying and implementing policies and guidelines relevant to their area of responsibility.

3.3 The Owner and Senior Manager

The named owner (originator) of a policy or guideline as well as any senior manager to a service is responsible for ensuring a subject matter expert is identified to support the development or review of a policy or guideline in a timely manner using the processes described within this document.

Senior Managers will support the Policy Management Team to ensure all policies and guidelines are developed and reviewed effectively and in a timely manner

Senior Managers are responsible for:

- Notifying members of staff within their service when a new or revised policy or guideline is used.
- Notifying new starters during their first week in post of how they can access the Trust's policies and guidelines, highlighting priority documents relevant to their role.
- Ensuring all staff have adequate access to policies and guidelines either by the Trust's intranet or paper copies if necessary. Please note that paper copies are not the preferred medium as there is no governance process to ensure these are refreshed upon revision.
- Identifying any training required to comply with individual policies.

3.4 All staff

All staff are responsible for co-operating with the development and delivery of policies and guidelines within their normal duties.

All staff are responsible for ensuring they maintain up to date with the Trust's policy set and seek advice and guidance from their line manager should they be unsure of how to access a policy or guideline or need clarity on the content of any policy or guideline.

3.5 The Subject Matter Expert

The Subject Matter Expert is the person given responsibility for developing or reviewing a policy or guideline and is deemed the expert of the topic rather than the expert in the design, layout and formatting of a policy or guideline document. The Policy Management Team will oversee those tasks to ensure consistency as well as ease the burden on Subject Matter Experts and services and will gain approval from the Subject Matter Expert prior to publication.

The subject matter expert is expected to use the processes described within this document as well as the support and resources made available to them for the development and review of policies and guidelines.

3.6 Committees and Workgroups

An established Committee or Workgroup is required to support a Subject Matter Expert in the development or review of a policy or guideline. This includes the completion of supporting documents; e.g. the Equality Impact Assessment Tool, any form or document planned to be appendixed to the policy or guideline and any flowchart or algorithm designed to accompany the policy or guideline.

The relevant Committee or Workgroup will support the Subject Matter Expert to ensure the policy or guideline is shared appropriately for consultation and will ensure any comments are taken into consideration and the document is amended accordingly prior to sharing with the Policy Management Team in preparation of presentation at Panel.

- **Audit Committee**

The Audit Committee is responsible for reviewing the Trust's establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that support the achievement of the Trust's objectives.

- **Health Informatics Steering Group**

HI policies are approved at the Health Informatics Steering Group prior to being presented to the Policy & Guidelines Panel.

- **Infection Prevention & Control Committee**

IPC polices are presented and approved at IPC Committee prior to being presented to the Policy & Guidelines Panel.

- **JNCC**

HR policies are agreed and ratified at Consultation meeting with staff side and then submitted to JNCC for acknowledgement prior to being presented to the Policy & Guidelines Panel.

- **Performance and Finance Committee**

Updates, amendments and revisions to the "F" policies are discussed at the Performance and Finance Committee prior to being presented to the Policy & Guidelines Panel.

Any other policies that reference financial responsibilities should also be submitted for review as they arise.

3.7 Knowledge Management

The Knowledge Service is responsible for supporting access to up to date evidence and best practices. Subject Matter Experts are expected to search for and include all relevant up to date references to reports and research that relate to the policy.

The Knowledge Service is available to support Subject Matter Experts by providing training/advice for searching and document supply services for documents not freely available on the internet.

3.8 Equality & Diversity Team

The Equality & Diversity Team is responsible for helping the Subject Matter Expert in ensuring that the policy being written or revised will assess and address the concepts as underpinned by the Equality Act, to ensure that there is no detrimental impact which could potentially lead to harassment, victimisation, direct or indirect discrimination. The team also helps in supporting the completion of an Equality Impact Analysis assessment prior to the policy being ratified. Trust-developed guidelines do not require of an Equality Impact Analysis assessment.

3.9 Freedom of Information Team

The Freedom of Information Team will assess all Freedom of Information (FOI) Exemption Assessment forms completed by the subject matter experts.

The FOI Team will consider the assessment and will establish if the policy requires publication. Trust-developed guidelines do not require external publication and an assessment does not need to be completed for these.

3.10 Information Governance Team

The Information Governance Team will assess and establish if the policy is compliant with relevant information law and standards, and is consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Whilst not all policies will require input from the Information Governance team, consideration should be given to seeking advice from the team as the policy is being developed.

3.11 Safeguarding Team

The Safeguarding team will be responsible for ensuring that policies reflect national and local requirements to safeguard and protect children and vulnerable adults.

3.12 The Policy & Guideline Panel

The Panel meets on a regular basis and receives newly developed and reviewed policies and guidelines by presentation from Subject Matter Experts. The Panel is responsible for overseeing that all documents presented meet all requirements described in this document prior to publication and thereafter. The Panel Chair oversees the work of the Policy Management Team.

3.13 The Policy Management Team

The Policy Management Team sits within the Clinical Effectiveness and Quality Improvement Team and is responsible for the day-to-day management of the processes described in this document.

The Policy Management Team will work closely with the Subject Matter Expert to ensure consistency in the development and review of policies and guidelines as well as to ease the burden on Subject Matter Experts and services and will use a standardised approach to the format, layout and formatting of all documents in the Trust's policy set.

Other responsibilities include:

- Management of all systems used
- Close collaboration with all professionals involved in all aspects of development and review of policies and guidelines
- Co-ordination of Panel meetings
- Preparation of update reports to the Trust Management Board.

3.14 Clinical Audit Project Manager

The Clinical Audit Project Manager will support the Policy Management Team and Subject Matter Experts to ensure all policies and guidelines include measurable performance standards and indicators to enable consistent measures of adherence.

3.15 NICE Implementation Project Manager

The NICE Implementation Project Manager will support the Policy Management Team and Subject Matter Expert to ensure all policies and guidelines reflect the appropriate NICE guidelines and standards prior to a policy or guideline being presented to the panel.

3.16 Assurance and Compliance Officer

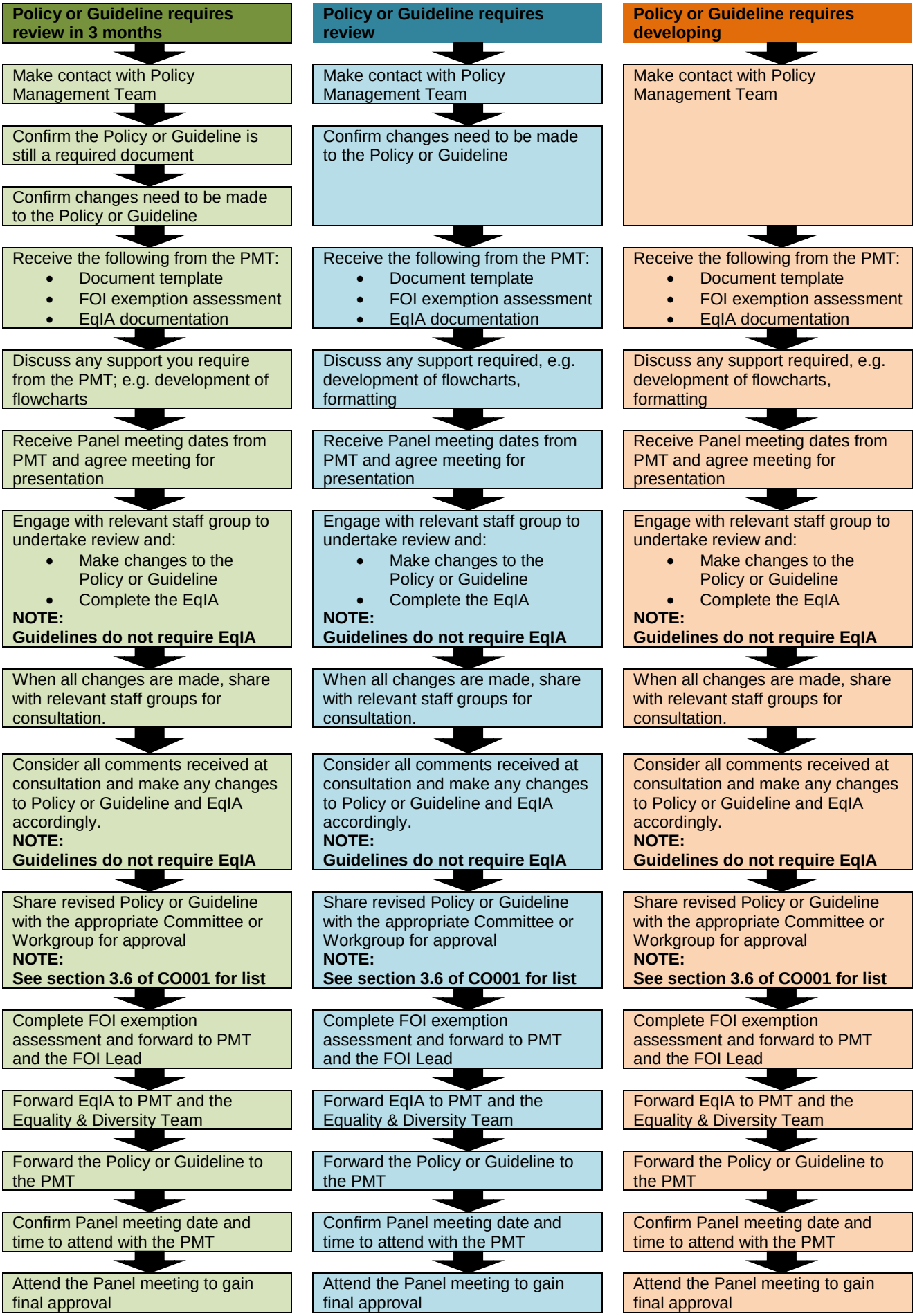
The Assurance and Compliance Officer will support the Policy Management Team and Subject Matter Experts to ensure all policies and guidelines are aligned to the appropriate CQC Regulations prior to a policy or guideline being presented to the panel.

4. THE PROCESS

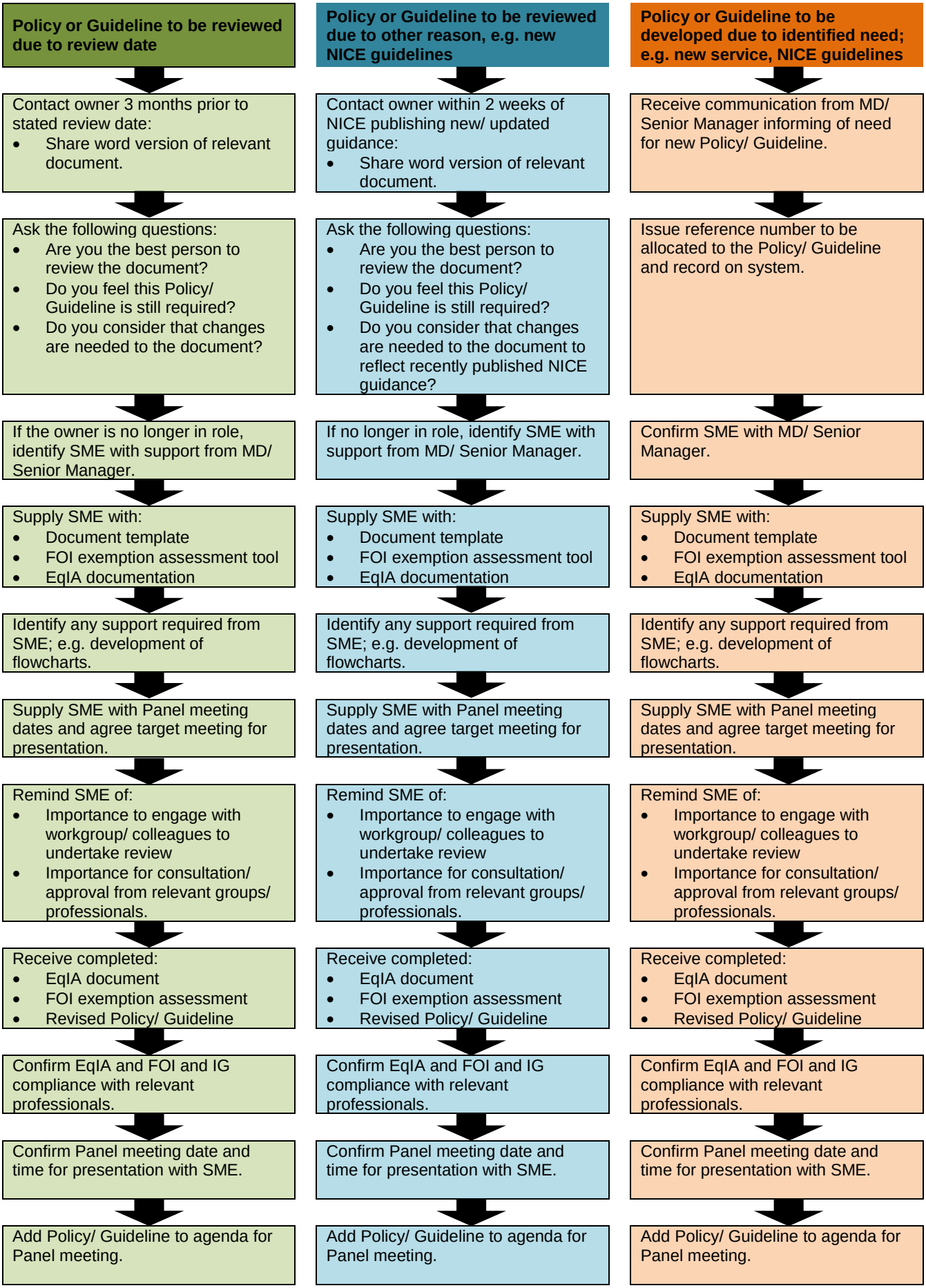
The process to develop or review a policy or guideline is written against three pathways and each pathway can consistently be identified throughout this section as well as throughout the How to Guides (Section 11) by the following colour codes:

	Policies and guidelines being reviewed as planned on a 3-yearly basis.
	Policies and guidelines being reviewed prior to the 3-year review date due to affecting circumstances such as changes to service delivery, NICE guidance being published or statutory requirement.
	Policies and guidelines being developed due to an identified need by the team/service/organisation.

4.1 The Process (Subject Matter Experts perspective)



4.2 The Process (Policy Management Team's perspective)



5. GENERIC STATEMENTS

To ensure a standardised and consistent approach to the Trust's policy set, a set of generic statements have been developed by the relevant experts in each subject area.

These statements will be included in all policies and guidelines (note: Equality Impact Analysis and Freedom of Information Exemption assessments do not apply for Guidelines). In some instances the subject matter expert may require specific details including in a document and that will sit alongside these generic statements; for example, regulatory monitoring requirements.

5.1 Monitoring

To ensure a consistent approach is used throughout the organisation in relation to the method used to monitor performance standards detailed within a policy or guideline a generic statement has been produced and it is advised that this is used within all documents. There may be instances that more detail is required for staff and in those instances it is advised to include at least the following generic statement.

> *The effective application of this policy / guideline, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.*
>
> *Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.*

5.2 Review

To ensure a consistent approach is used throughout the organisation in relation to the timeliness of reviewing policies and guidelines a generic statement has been produced and it is advised that this is used within all documents.

> *This policy / guideline will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.*

5.3 Equality Impact Analysis

To ensure a consistent approach is used throughout the organisation in relation to detailing the completion of an equality impact assessment against a policy or guideline a generic statement has been produced and it is advised that this is used within all documents.

> *As part of its development, this document was analysed to consider and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure.*

5.4 Freedom of Information Exemption Assessment

To ensure a consistent approach is used throughout the organisation in relation to Freedom of Information assessment against a policy or guideline a generic statement has been produced and it is advised that this is used within all documents.

> *Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.*

5.5 Information Governance Assessment

To ensure a consistent approach is used throughout the organisation in relation to Information Governance assessment against a policy or guideline a generic statement has been produced and it is advised that this is used within all documents

> *This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.*
>
> *Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.*

5.6 Safeguarding

To ensure a consistent approach is used throughout the organisation in relation to Safeguarding a generic statement has been produced and it is advised that this is used within all documents

> *All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.*
>
> *All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.*

6. MONITORING

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

7. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

8. EQUALITY IMPACT ANALYSIS

As part of its development, this policy was analysed to consider its effect on different groups protected from discrimination by the Equality Act 2010. The requirement is to consider if there are any unintended consequences for some groups, and to consider if the policy will be fully effective for all protected groups. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers or advance equality in the delivery of this policy.

9. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

All policies will be published on the Trust's external website unless an exemption from disclosure under the Freedom of Information Act (2000) applies. The policy owner will review the FOI Exemption Guide, and complete the FOI Exemption Assessment form. The FOI team will then assess the policy and the form to establish if any exemptions apply and whether the policy should be published in whole or redacted.

10. INFORMATION GOVERNANCE ASSESSMENT

To ensure that policies are both compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

11. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

12. HOW TO GUIDES

The **How to Guides** describes the process to follow, with particular emphasis given to the perspective of the Subject Matter Expert.

The Subject Matter Expert is considered the expert of the content which other individuals and staff groups will be required to follow. The Subject Matter Expert is not considered to be the expert in formatting the document using a consistent approach, developing bespoke flowcharts and algorithms, or completing all the necessary governance requirements single-handed prior to publication.

a) How to complete the document control
b) How to identify key words
c) How to search and locate the best evidence
d) How to involve the right people
e) How to identify feasible and appropriate training requirements
f) How to monitor adherence to a policy / guideline
g) How to reference
h) How to prepare for presentation to the Panel
i) How to develop a flowchart
j) How to format a policy / guideline
k) How to attach appendices
l) How to manage version control
m) How to complete the EqIA documentation
n) How to decide where to publish and raise awareness

13. REFERENCES

Freedom of Information Act 2000

Mental Health Act

Equality Act 2010